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Modern Concepts of Cardiovascular Disease

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THE MANAGEMENT OF DISTURBED CARDIAC PATIENTS*

PART II

General Approach to the Problem of Diagnosis

Obviously the correct diagnosis is important in deciding what to do for the disturbed patient. It is well to consider as a minimum the conditions mentioned above when cardiac patients exhibit disturbed states. General steps should include:

(1) Determine from the family whether the patient has had previous psychologic disturbance, or whether he has been institutionalized. Determine whether the condition was of acute onset or whether the patient had been developing psychologic or behavior difficulties over a number of years. Sometimes the patient's history must be obtained by telephone from relatives, neighbors, or friends. In addition to observing the patient's disturbed state, it is also important to do a new physical and neurological examination, as new disease may have developed. A disturbed state developing in a cardiac patient indicates that the whole medical situation should be re-evaluated.

(2) Examine the temperature chart for evidence of even slight fever.

(3) Re-examine the list of drugs to consider whether the patient is being over-drugged, or if any drug can be omitted; determine if the patient has been given drugs by another physician.

(4) Perform certain tests. A determination of blood bromides may reveal unsuspected bromide poisoning; electrolyte studies or determinations of CO_2 content or combining power of

the blood may show abnormalities; lumbar puncture may disclose evidence of paresis, meningitis, or brain hemorrhage. It should be remembered that patients with high venous pressure have high spinal fluid pressure. To what extent high intracranial pressure under these circumstances contributes to symptomatology is not known. It is well to determine the level of nonprotein nitrogen or urea in the blood; this is often an important negative finding. Generally speaking, renal failure or uremia does not explain most disturbed states in cardiac patients.

Management and Treatment

1. Specific Treatment

The most important step in the treatment of disturbed states complicating heart disease is the specific treatment whenever specific treatment is available for the medical disease which accompanies the disturbed state. For instance, if the patient has pneumonia, bacterial endocarditis, or heart failure, treat them appropriately.

2. Specific Treatment of the Delirium

Except for special states such as bromidism, where the treatment is gradual substitution of chlorides for bromides, the specific treatment for delirium is for the most part specific treatment for the major illness or for its other complications.

3. Management of the Delirious State

a.) *Protection of the Patient*—This involves seeing that the patient does not fall out of bed, run out into the snow, or jump or fall out of the window, fall down steps, or pick open a surgical wound. The best single adjunct here is a trained nurse or attendant. It is a wise precaution to see that the windows are secured in

* From the Cardiac Research Laboratory, Department of Medicine and Neurology, The Massachusetts General Hospital and the Harvard Medical School.

such a way that the patient cannot fall or jump out. It should be remembered that the patient can wander into the next room or kitchen where the windows may be open. If the cardiac patient refuses to stay in bed and wishes to sit in a chair or walk around the hall, it is a matter of judgment to decide whether it is better to allow the patient to do this peacefully or to let him fight and struggle while he is forcibly restrained by the attendants, or whether it is better to over-sedate the patient. If mild sedation and subtle persuasion are ineffective, I personally prefer, even though I know there is risk of a fresh coronary occlusion, to allow a patient to sit in a chair, go to the bathroom, or go for a peaceful stroll rather than to render him stuporous with drugs or to have him fighting and shouting. In some cases, one gains the impression that the general situation is actually improved by allowing the patient to sit in a chair even though the experiment may seem hazardous.

In some case, restraint of hands and feet have a place in the short term management of patients, particularly in those patients who have had surgery and whose restless hands pick wounds and dressings, such as after cardiac surgery or surgery of the sympathetic system. If the patient is restless and not sleeping and seems frightened, one should put on the light; if, however, the light keeps the patient awake, it is best to do without it. Sometimes having a relative sit at the bedside is helpful, particularly, in my opinion, with sick children. However, it should be remembered that many relatives find attending delirious patients a very disturbing experience.

b.) *Feeding the Patient* — Disturbed patients sometimes eat only upon being coaxed to do so, or sometimes refuse food entirely. If artificial feeding must be resorted to, recall that the stomach is a good place for food. To pass a small nasal tube skillfully is not a difficult operation, and through this one may give fluids, medicines, food, and almost everything the patient needs. One must make sure that the tube is in the stomach and not in the lungs before putting in food. One should first place the end of the tube in a glass of water to see if bubbles appear; then when the tube is in place, a small amount of water should be run through to be sure that this does not provoke coughing or strangling. If bubbling, coughing, or strangling appear, the tube is not in the stomach and it should be removed and replaced in better position. Besides the fact that stomach feeding is

more satisfactory, it probably is a safer route than the vein for the administration of fluids to cardiac patients.

c.) *Drugs* — The rule to follow here is to omit all drugs that are not clearly necessary, to continue with all drugs which are specific and perhaps life-saving, and to substitute other forms of drugs for drugs that are necessary and of which there are various forms. If sedatives are necessary for sleep or for extremely disturbed behavior, we prefer paraldehyde or chloral hydrate to other drugs; a dose by mouth of 8 c.c. (two drams) of paraldehyde in ice cold ginger ale is tolerated well by most patients, and this can be repeated with safety as the situation demands.

d.) *Oxygen* — In patients for whom oxygen is deemed necessary, the patient may unfortunately sometimes struggle and fight in the oxygen tent. In these circumstances, try giving the oxygen by nasal catheter. If the patient still fights against this, it is then best to omit oxygen for a while and then try again, or discontinue oxygen altogether if it still provokes struggling.

e.) *What to Tell the Family* — It is well to explain to the family that delirious states are usually secondary to the patient's general condition and that, when he improves medically, the delirium will go away. It should also be explained to the family that delirium is not like ordinary "insanity," and that there is no evidence to show that this runs in families and that there is no reason to believe that the patient's past problems or difficulties caused the trouble, or that the family caused it. Families may be greatly upset by the appearance of disturbed states, particularly in cases where the patient is clear before coming into the hospital, and then becomes confused and develops abnormal behavior during hospitalization.

f.) *Where to Take Care of the Patient* — In general the best place to take care of the patient is in the place where he is. In certain types of medical institutions the nurses and staff may feel that the disturbed cardiac patient is too difficult to manage. However, even the most administratively formal hospital can be persuaded to keep a patient for a few days for a medical emergency, which these disturbed states really are. Some municipal hospitals are particularly adept at managing these patients. A modern hospital should be especially equipped to house a few disturbed patients. If the patient's behavior is extremely abnormal or if the patient is terribly combative or suicidal, one might finally transfer the patient to a psychiatric insti-

tution and arrange for his cardiac supervision there. If a patient's cardiac condition seems terminal and if he is in an excited condition, adequate sedation rather than commitment to a mental hospital is more appropriate. If the patient's heart disease or heart failure is merely an incident in unmanageable senile psychosis, institutionalization is sounder both for patient and family.

CONCLUSIONS

The problems of management of disturbed

cardiac patient involves:

(1) Precise diagnosis; (2) seeking out hidden complications; (3) treating what can be treated specifically; (4) nourishing the patient and protecting him against the hazards of his disturbed behavior.

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The opinions and conclusions expressed herein are those of the author and do not necessarily represent the official views of the Scientific Council of the American Heart Association.

AMERICAN HEART ASSOCIATION FELLOWSHIPS AND RESEARCH GRANTS-IN-AID

Applications for Established Investigators and for Research Fellows for the fiscal year 1954-1955 must be received in the office of the Association not later than September 15, 1953.

Applications for Research Grants-In-Aid or 1954-1955 must be received not later than December 1, 1953.

Information booklets and application blanks may be obtained from the Medical Director.

ANNUAL MEETING OF THE AHA, 1954

The Annual Meeting of the American Heart Association in 1954 will be held at the Conrad Hilton Hotel in Chicago. The Assembly Panels and the General Assembly will be held on Thursday and Friday, April 1 and 2, and will be followed by a specific scientific program on clinical cardiology on Saturday and Sunday, April 3 and 4, conducted under the auspices of the newly formed Section on Clinical Cardiology of the Scientific Council. These sessions will immediately precede the annual meeting of the American College of Physicians.

SCIENTIFIC PROGRAM OF THE SECTION ON CLINICAL CARDIOLOGY 1954

The Section on Clinical Cardiology of the American Heart Association will sponsor a two-day scientific program at the Conrad Hilton Hotel in Chicago on April 3 and 4, 1954. This program will constitute a portion of the Annual Meeting of the American Heart Association and immediately precedes the Annual Sessions of the American College of Physicians. The meeting will be open to all members of the medical profession. Doctor Wright R. Adams of Chicago is Chairman of the Program Committee. Members of the American Heart Association who wish to present papers should send a 250-300 word abstract of the proposed paper to Doctor Charles D. Marple, Medical Director, American Heart Association, Inc., 44 East 23rd Street, New York 10, New York. *All papers should be on subjects of distinct clinical interest. The deadline for the receipt of abstracts is January 1, 1954.*

ANNUAL SCIENTIFIC SESSIONS, 1954, and THE SECOND INTERNATIONAL CONGRESS OF CARDIOLOGY

The 27th Scientific Sessions of the American Heart Association will *not* be held at the usual time in 1954, but will take place following the 2nd. International Congress of Cardiology in September. The International Congress of Cardiology will be held in Washington, D.C., September 12 through 15, 1954 and the Scientific Sessions of the American Heart Association will also be held in Washington, September 16 through 19.

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